PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY | STATE | ZIP

PHONE | FAX

CELL | EMAIL

BIRTHDATE | AGE | MALE ☐ | FEMALE ☐

MARRIED ☐ | SINGLE ☐ | DIVORCED ☐ | WIDOWED ☐

SOCIAL SECURITY NO.

DATE

LAST NAME | FIRST | M.I.

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE ☐ | FEMALE ☐

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS. FILL IN THE TOP BOX ALSO

2

DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

3

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

Signatures and dates on these pages will be added when the forms are printed out at our office on your first visit. When finished submit the filled-in forms by email by clicking the SUBMIT button on the last page

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

If forms are filled out online, then signature pages will be printed out at the office to be dated and signed there

Patient Name	Date

DENTAL HISTORY

Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completelty confidential

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ☐Yes ☐No

If yes, please describe: _____

_____

Are any of your teeth sensitive to:

Hot or cold? ☐Yes ☐No
Sweets? ☐Yes ☐No
Biting or Chewing? ☐Yes ☐No
Have you noticed any mouth odors or bad tastes? ☐Yes ☐No
Do you frequently get cold sores, blisters or any other oral lesions? ☐Yes ☐No

Do your gums bleed or hurt? ☐Yes ☐No
Have your parents experienced gum disease or tooth loss? ☐Yes ☐No
Have you noticed any loose teeth or change in your bite? ☐Yes ☐No
Does food tend to become caught in between your teeth? ☐Yes ☐No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? ☐Yes ☐No
Bite your lips or cheeks regularly? ☐Yes ☐No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐Yes ☐No
Mouth breathe while awake or asleep? ☐Yes ☐No
Have tired jaws, especially in the morning? ☐Yes ☐No
Smoke/chew tobacco? ☐Yes ☐No

Have you ever had:

Orthodontic treatment? ☐Yes ☐No
Oral surgery? ☐Yes ☐No
Periodontal treatment? ☐Yes ☐No
Your teeth ground or the bite adjusted? ☐Yes ☐No
A bite plate or mouth guard? ☐Yes ☐No
A serious injury to the mouth or head? ☐Yes ☐No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw? ☐Yes ☐No
Pain? (joint, ear, side of face) ☐Yes ☐No
Difficulty in opening or closing the mouth? ☐Yes ☐No
Difficulty in chewing on either side of the mouth? ☐Yes ☐No
Headaches, neckaches or shoulder aches? ☐Yes ☐No
Sore muscles (neck, shoulders)? ☐Yes ☐No

Are you satisfied with your teeth's appearance? ☐Yes ☐No
Would you like to keep all of your teeth all of your life? ☐Yes ☐No

Do you feel nervous about having dental treatment? ☐Yes ☐No
If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? ☐Yes ☐No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? ☐Yes ☐No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name	Date

MEDICAL HISTORY

Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? ☐ Yes ☐ No

   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☐ No

   If yes, did you take any of the following:
   - ☐ Yes ☐ No Fen-Phen (Fenfluramine-Phentermine)
   - ☐ Yes ☐ No Pondimen (Fenfluramine)
   - ☐ Yes ☐ No Redux (Dexfenfluramine)

   If yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? ☐ Yes ☐ No

   If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Hepatitis A (infectious) B (serum)	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	A.I.D.S	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	H.I.V. Positive	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Contact lenses	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Latex Sensitivity	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Allergies or Hives	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Diet (Special/Restricted)	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Nervous/Anxious	☐ Yes ☐ No
Kidney Trouble	☐ Yes ☐ No	Tumors	☐ Yes ☐ No	Psychiatric/Psychological Care	☐ Yes ☐ No

8. Do you use more than two pillows to sleep? ☐ Yes ☐ No
9. Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No

    If yes, please list: _____
11. **Women.** Are you: **Pregnant?** ☐ Yes, _____ Months ☐ No **Nursing?** ☐ Yes ☐ No **Taking birth control pills?** ☐ Yes ☐ No

I understand the above information is needed to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication

Patient/Guardian Signature _____ Date _____

History Review

(CLICK HERE TO SUBMIT FORM BY EMAIL)

Your computer may take up to 10 minutes to process the form and open your email program to send

Dentist Signature _____ Date _____